Allied Health Professions Australia

Submission to Independent Health and Aged Care Pricing Authority on Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2025–26

September 2024

This submission has been developed in consultation with AHPA's allied health association members.

Allied Health Professions Australia
Level 1, 530 Little Collins Street
Melbourne VIC 3000
www.ahpa.com.au
office@ahpa.com.au

About Allied Health Professions Australia and the allied health sector

Allied Health Professions Australia (AHPA) is the recognised national peak association for Australia's allied health professions. AHPA's membership consists of 28 national allied health associations and a further 12 affiliate members, each representing a particular allied health profession. AHPA collectively represents some 200,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners, including the largest rural and remote allied health workforce numbering some 14,000 professionals.

Allied health professionals work across a diverse range of settings and sectors, including providing diagnostic and first-contact services, and preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses.

Allied health practitioners also support pre- and post-surgical rehabilitation and enable participation and independence for people experiencing temporary or long-term functional limitations. Allied health therefore provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

Working with a wide range of working groups and experts across the individual allied health professions, AHPA advocates to and supports Australian governments in the development of policies and programs relevant to allied health.

Overview

AHPA's submission only responds in detail to Question 5 of the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2025-26 ('Consultation Paper'). However, with respect to Questions 1, 2 and 4, we refer to and endorse the submission and associated recommendations from our member Speech Pathology Australia.

AHPA reiterates the emphasis of our 2023 submission to IHACPA on the Pricing Framework for Australian Residential Aged Care Services 2024-25 ('2023 submission'), that the present approach to costing and pricing allied health is fundamentally flawed. Current methodology is premised on the assumption that the amounts and types of allied health care currently provided is sufficient to meet the needs of residents. But on the contrary, allied health care is significantly underprovided and underfunded – and continues to decrease, with the latest figure being just over half the amount that the Royal Commission into Aged Care Quality and Safety ('Royal Commission') found to be grossly inadequate.

While AHPA appreciates that many of the contributing factors to the present context are outside IHACPA's ambit and mandate, nevertheless the pricing system is required to support the delivery of high quality, person-centred care.

It is therefore incumbent upon IHACPA to at least alert the Department of Health and Aged Care ('the Department') that significant aged care system improvements need to be made before IHACPA costing and pricing of allied health can fulfil its function. AHPA is therefore pleased to see the establishment of the Program Management Board to facilitate strategic pricing and policy discussions between IHACPA and the Department.

Once the interrelationship between policy and pricing is addressed, Government determination of the value of the National Weighted Activity Unit ('NWAU') and associated Australian National Aged

Care Classification ('AN-ACC') weightings can reflect the true cost of meeting the allied health needs of aged care residents.

Recommendations

Recommendation 1

Residential aged care pricing principles should be considered and applied under an overarching principle of reablement, with associated commitment to multidisciplinary team care.

Recommendation 2

IHACPA should collaborate with the Department of Health and Aged Care to review the impact of AN-ACC and the focus on delivering the required care minutes, on the provision of allied health services in residential care settings.

Recommendation 3

IHACPA should collaborate with the Department of Health and Aged Care to support the introduction of a nationally consistent allied health needs assessment and care planning process.

Recommendation 4

In order to inform accurate pricing advice, IHACPA should recommend to the Commonwealth Government that a pilot study be funded to capture appropriate data examining the real cost of allied health care per AN-ACC class.

Recommendation 5

IHACPA should work with the Commonwealth Government to adjust the AN-ACC pricing framework to reflect the costs of providing allied health services based on individually assessed allied health needs.

Allied health provision in residential aged care

Allied health service provision in residential aged care remains in a parlous state. As our 2023 submission outlined, the Royal Commission identified 'reablement' as critical to older people's physical and mental health and wellbeing. The Royal Commission found, as also acknowledged in IHACPA's Consultation Paper (20), that allied health care is critical to producing reablement.

Our 2023 submission detailed how research undertaken for the Royal Commission found that aged care residents received an average of only eight minutes of allied health care a day, in contrast to the allied health care figure in British Columbia, Canada of 22 minutes.[1]

The Royal Commission therefore concluded that Australia's significant under provision and undervaluing of allied health care must be addressed. The Royal Commission recommended that

[1] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and R Gordon, 'How Australian residential aged care staffing levels compare with international and national benchmarks', Centre for Health Service Development, AHSRI, University of Wollongong, 2019 https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf , 24-25.

aged care provided to people at home and in residential facilities include a level of allied health care appropriate to each person's needs.

This level of service provision requires needs-based assessment, so the Royal Commission recommendations also emphasise clinically assessing each person, ideally via a multidisciplinary team, against the full range of potentially available allied health services that could help maintain their wellbeing and assist reablement.[2] These assessed needs must then be met via ringfenced funding and coordinated care planning.

More recently, the Inspector-General of Aged Care has called for the Commonwealth Government to implement the needs-based approach that the Royal Commission envisaged.[3] However, despite considerable reforms since the Royal Commission's Final Report, there is no dedicated funding for allied health services in residential aged care, and no associated mandatory benchmark equivalent to nursing and personal care minutes. Instead, the Department expects provider payment for allied health services in residential aged care to be drawn from overall federal Government funding to providers under the new AN-ACC model.[4]

Quarterly Financial Reporting of allied health

Our 2023 submission discussed Quarterly Financial Reporting ('QFR') in some detail, because IHACPA costing relies upon it as a key source of data. The current Consultation Paper (20) describes QFR as 'enabling IHACPA to better understand the costs of care provided by the different types of allied health professions when undertaking future cost collections'.

Beginning with the first data period that reflected the impact of the new AN-ACC model, the October to December 2022 Quarterly Financial Snapshot ('QFS') reported an allied health average per resident per day ('PRD') of 4.6. The comparable figure for January to March 2023 was 4.55 minutes PRD. Since our 2023 submission, allied health has further decreased to 4.26 minutes PRD, then to 4.21, and most recently, 4.11.[5]

Allied health service provision is therefore now just over half the amount criticised as grossly insufficient by the Royal Commission.

The past five QFSs have also provided some more detailed data on allied health costs and time spent on residential aged care, as the table overleaf summarises.

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[2] See eg Royal Commission Recommendations 36, 38 and 41, and more broadly Recommendations 25, 31, 37, 58 and 69.

[3] Office of the Inspector-General of Aged Care, *2024 Progress Report on Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety*, 7. The Progress Report (Appendix A) notes that the relevant Recommendations (see footnote 2) have only been partially progressed, and that the 'transformative' Recommendations 25 and 41 (needs-based services and one unified aged care system) that were rejected by Government should be implemented in full.

[4] For more specific discussion of the relationship between AN-ACC and allied health service under provision, see our response to Consultation Question 5 below.

[5] Data in this section of the submission is from Department of Health and Aged Care, Quarterly Financial Snapshots of the Aged Care Sector: Quarter 2 2022-23 (October to December 2022), 13-14; Quarter 3 2022-23 (January to March 2023), 15; Quarter 4 2022-23 (April to June 2023), 16-18; Quarter 1 2023-24 (July to September 2023), 15-18; Quarter 2 2023-24 (October to December 2023), 18, 22-23.

Individual allied health profession minutes PRD over time

QFS	Physiotherapy	Speech Pathology	Podiatry	Dietetics
Oct–Dec 2022 (Q2 2022-23)	2.97	0.04	0.20	0.10
Jan–Mar 2023 (Q3 2022-23)	2.96	0.05	0.21	0.12
Apr–Jun 2023 (Q4 2022-23)	2.73	0.06	0.23	0.12
Jul–Sept 2023 (Q1 2023-24)	2.75	0.06	0.21	0.13
Oct–Dec 2023 (Q2 2023-24)	2.66	0.06	0.24	0.14

Other than the four professions in the table above, there has been a continuing trend of between 70 and 80 per cent of QFR respondents not reporting any minutes or expenditure for the categories of occupational therapists, allied health assistants and other allied health categories specified in QFR.

As one specific detailed example of individual allied health service under provision, AHPA also refers IHACPA to the submission on the Consultation Paper from our member Dietitians Australia, which outlines research findings concerning dietetic services in Australian residential aged care.

Other allied health data

The Australian Institute of Health and Welfare ('AIHW') 2023 Aged Care Provider Workforce Survey shows that between 2020 and 2023 the number of allied health professionals and assistants working in aged care homes decreased by 42 per cent.[6] It is clear from both the overall recorded decline and individual AIHW Workforce Survey data tables that allied health is significantly under provided. Just one example is the total national headcount of 64 psychologists, noting further that it is unlikely that most of those psychologists are working fulltime in aged care.

AHPA's own 2023 survey of allied health professionals (AHPs) working in residential aged care found that just over half of respondents said their role had changed since introduction of the AN-ACC funding model.[7] Almost one in five of those respondents had lost their role, and 48% had their hours decreased. Others were leaving the sector or considering doing so due to concerns about declining service quality. This exodus then exacerbates the problem, leaving fewer professionals to provide essential services.

Aged care residents and their families have reported to AHPA their experiences of trying to obtain allied health services, including being told that the facility does not have these available and that they will have to find care themselves. At best, if they can afford to do so, consumers are then left out of pocket trying to access services via private health, or they may receive a maximum of five

[6] Australian Institute of Health and Welfare (2024) *2023 Aged Care Provider Workforce Survey: Summary Report*, Australian Government.

[7] https://ahpa.com.au/advocacy/summary-of-results-from-survey-of-allied-health-workforce-in-residential-aged-care-2023/ .

Medicare-subsidised treatments per year – or they simply have to pay for it entirely out of their own pocket, or go without.[8]

This crisis is likely to continue when, as the Inspector-General has noted, despite Royal Commission Recommendation 69 that allied health care should generally be provided by aged care providers, there is still no clarification of the various funding responsibilities for aged care.[9]

Impacts on aged care safety and quality

IHACPA regards safety and quality as elements of pricing policy objectives that must be balanced against other considerations when providing pricing advice (Consultation Paper, 22). Further:

> 'Objectives include promoting the person-centred, quality care expected by the community in line with the Aged Care Quality Standards, while supporting improvements in the sustainability and efficiency of the aged care system over time. This is the overarching framework within which IHACPA makes its policy decisions and provides its pricing advice.' (ibid)

The scarcity of allied health in residential aged care has clear implications for pricing policy objectives. Residents are generally not obtaining care that would prolong their functioning and quality of life and reduce the losses and costs of having to be hospitalised.

There are other significant risks to residents. There is at least anecdotal evidence that aged care providers are substituting 'cheaper' workers from outside allied health, such as personal care workers and lifestyle staff, to provide services that considerations of quality and safety require to be delivered by an allied health professional.

The AIHW Workforce Survey data tables provide a total headcount of AHPs and allied health assistants (AHAs) in residential aged care of 6447, of which 1974 are AHAs. The total for AHAs exceeds the headcount for any single allied health profession in aged care – even physiotherapy which has the largest individual headcount of 1671. It means that AHAs are 31% of the allied health workforce in residential aged care.

The fact that a large proportion of the allied health aged care workforce are AHAs should be viewed in the context of AHPA's 2023 survey which found that providers are sometimes using AHAs to carry out tasks that should be undertaken by AHPs. While AHAs are a valuable part of the workforce, it can be inappropriate and dangerous to substitute them as a supposedly 'cheaper' option, especially if they are not supervised by a professional.

Implications for allied health costing and pricing

The Consultation Paper states that 'IHACPA's residential aged care pricing advice is intended to cover the cost of care' (7), and that 'the 2023 RACCS [Residential Aged Care Costing Study] captured the costs of care provided by allied health' (20).

As AHPA emphasised in our 2023 submission, the fundamental flaw in the present costing and pricing approach to allied health care is that it only addresses the substandard level of allied

[8] The impact of Parts 2 and 3 of the Schedule of Specified Care and Services to the *Quality of Care Principles 2014* on allied health service provision and consumer cost is discussed in detail in our 2023 submission.
[9] Office of the Inspector-General of Aged Care, *2024 Progress Report on Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety*, 41.

health care currently provided – not the allied health care people might be clinically assessed to need.

The 2023 RACCS took this limited approach via its partial reliance on QFR data, the limitations of which are discussed above. The RACCS also used proximity devices aimed at recording allied health service provision, but some direct care time was missed due to residents not wearing the devices.[10]

Out of the RACCS finding of 52 minutes per day of direct care per permanent resident, 13 minutes in total were reported for nursing, lifestyle, care managers, allied health and 'other'.[11] These sub-categories were deemed too small to be reported as separate figures and were only presented in graph form. It appears from the graph that the resulting average daily minutes of allied health reported from the RACCS was lower than any result obtained via QFR.[12]

Other weaknesses in the RACCS included:

- lack of delineation of allied health according to individual professions – particularly problematic in a costing study because costs can vary across professions;
- lack of delineation on the basis of whether the allied health provider is an employee of the aged care provider or a contractor – important, because pricing often varies on this basis;
- reference to allied health students, but no quantification of their contribution to direct care time; and
- some apparent confusion between lifestyle and allied health costs.

Consultation question 5

What, if any, changes should IHACPA consider for the proposed updated residential aged care pricing principles, which take into consideration a move toward revised funding model terminology?

As the Royal Commission and the Inspector-General of Aged Care have recommended, reablement should be embedded in the aged care system, and provision of allied health services and other aged care should be provided at a level that meets residents' clinically assessed needs.

Allied health workforce costing and pricing must therefore ensure that the full breadth of allied health services and associated skillsets are available as needed. To achieve this, costing and pricing principles must be capable of addressing the core issues currently preventing meaningful costing and pricing of allied health services in residential aged care.

Treat reablement as a core requirement of aged care

The various pricing principles should be considered and applied against a background of reablement.

If reablement is to be treated seriously as a core concept in Australia's aged care system, costing and pricing must also facilitate multidisciplinary team care. At a minimum, provision should be made for the delivery of care by the suite of allied health professions listed in Royal Commission Recommendation 38(b), including mental health practitioners, podiatrists, physiotherapists,

[10] Scyne Advisory for IHACPA, *2023 Residential Aged Care Costing Study*, November 2023, 12.
[11] Ibid, 3-5.
[12] It is not known how much time failed to be recorded as a result of some residents failing to wear devices, and hence whether this had a significant impact on the final allied health figures.

occupational therapists, speech pathologists, dietitians, exercise physiologists, music therapists, art therapists, optometrists and audiologists.

Costing, pricing and funding must also incorporate more than simply adding together individual professional time spent. For example, team coordination and support must be provided.

Recommendation 1

Residential aged care pricing principles should be considered and applied under an overarching principle of reablement, with associated commitment to multidisciplinary team care.

Review the impact of the AN-ACC and care minutes on allied health provision

Given the current under provision of allied health in residential aged care, pricing principles and analyses must scrutinise the Government assertion that AN-ACC funding to providers ensures sufficient payment for allied health services in residential aged care.

If 'the AN-ACC funding model is underpinned by an explicit incentive for high quality care, with a focus on restorative care and reablement' (Consultation Paper, 20), that incentive is not producing the desired outcomes for allied health.

For example, the premise that 'the AN-ACC classification system provides a meaningful way of relating residents' characteristics to the resources required to deliver their care' and 'allows the output of service providers to be measured to inform pricing, funding, budgeting and benchmarking' (Consultation Paper, 13) does not hold true for allied health.

As AHPA outlined in our 2023 submission, the AN-ACC is a funding tool which is not designed for allied health funding needs, and does not itself assess or prescribe the amount or types of allied health care to be provided. The architects of the AN-ACC emphasised that the current version of the AN-ACC is only the first step in a necessary development process,[13] and that adequately building allied health into the AN-ACC would take several years.[14]

A further limitation on allied health provision has developed via the interrelationship of AN-ACC funding and the introduction of mandatory minutes for personal and nursing care.[15] These 'care minutes' have, in effect, set benchmarks via which providers have begun to allocate portions of the overall AN-ACC funding that the Commonwealth Government provides to them to spend on direct care.

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[13] Eagar K, Westera A, Snoek M, Kobel C, Loggie C & R Gordon, 'How Australian residential aged care staffing levels compare with international and national benchmarks', Centre for Health Service Development, AHSRI, University of Wollongong, 2019, https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf , 33.

[14] Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, *AN-ACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6*, Australian Health Services Research Institute, University of Wollongong, 2019, 8-10. See also Professor Kathy Eagar and Dr Conrad Kobel, Australian Health Services Research Institute, 'Letter to Beth Midgley, Director Policy', Royal Commission into Aged Care Quality and Safety, October 2020, 3; https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ .

[15] Diane Gibson and Stephen Isbel, 'Reform and reverberation: Australian aged care policy changes and the unintended consequences for allied health' Australian Occupational Therapy Journal 2024 June, 71(3): 392-407 https://doi.org/10.1111/1440-1630.12953 .

In the absence of a comparable benchmark and ringfenced funding for allied health care provision, there is no guarantee that AN-ACC funds will be spent on allied health – or indeed, on any direct form of care, despite Government intention.

For example, the latest *Aged Care Sector Mid-Year Report* concludes:

> 'it appears that, on average, homes are generating surpluses from direct care services (primarily taxpayer-funded) to cross-subsidise losses from everyday living and accommodation.'[16]

The Inspector-General of Aged Care has also noted the effects on residents' access to allied health, and supports the Department initiating a review of the impact of the interrelationship of the AN-ACC and care minutes on the provision of allied health in residential care.[17]

The Inspector-General suggests that the Department consider:

> 'whether other policies, such as legislating a requirement for providers to spend all their care subsidy on the provision of enablement-focused care, could offer an effective means of realising the Royal Commission's intent. . . It is timely to reconsider whether the AN-ACC remains responsive to the needs and pressures associated with delivering high-quality residential aged care with a reablement focus.'[18]

Recommendation 2

IHACPA should collaborate with the Department of Health and Aged Care to review the impact of AN-ACC and the focus on delivering the required care minutes, on the provision of allied health services in residential care settings.

Consider assessment of allied health needs

Neither IHACPA's methodology nor QFR facilitates mapping of whether residents actually receive the amount and types of services that they are clinically assessed as needing. More fundamentally, there is no nationally consistent needs assessment process for allied health.

As noted above, the AN-ACC assesses residents for funding purposes, not for delivery of appropriate care. Once the assessor workforce determines the AN-ACC funding classification level, it is then up to facility staff to identify any perceived allied health needs. Whether the resident ends up receiving allied health services depends on existing staff skills and breadth of knowledge of different types of allied health, and so may only occur in response to an adverse event, and may vary by provider facility and even among individual staff.

Government cannot claim to meet aged care residents' allied health needs when these are not being reliably and consistently identified in the first place. Similarly, IHACPA cannot confidently provide the allied health pricing advice for Government funding consideration that meets the objective of 'promoting the person-centred, quality care expected by the community in line with the Aged Care Quality Standards' (see above).

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[16] UTS Ageing Research Collaborative, *Australia's Aged Care Sector: Mid-Year Report (2023–24)*, 21; and see more generally, 11-12, 21-29.
[17] Office of the Inspector-General of Aged Care, *2024 Progress Report on Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety*, 42.
[18] Ibid.

The aged care system needs a nationally consistent, evidence-based, assessment and care planning tool, to be used consistently to identify, plan for and deliver the allied health needs of individual aged care residents and consumers receiving home care. This reform is not only necessary to ensure high quality care – it is essential for valid costing and pricing of allied health service provision in a high quality aged care system, with associated implications for funding.

Recommendation 3

IHACPA should collaborate with the Department of Health and Aged Care to support the introduction of a nationally consistent allied health needs assessment and care planning process.

Translate reformed principles into future costing and pricing

AHPA understands that IHACPA's current Residential Aged Care Costing Study is intended to improve upon QFR data. QFR does not report the amount or cost of allied health care provided to residents against each of the 13 AN-ACC classes. It is therefore not possible to ascertain from QFR whether, for example, older people with high or complex needs receive more allied health services on average than higher functioning residents.

If IHACPA's costing approach is able to consider the amount of care provided to each individual resident, that will also enable analysis of the amount of care provided by AN-ACC class. It is important that costing and pricing be informed by data on allied health care reported against AN-ACC classes, so that Government determination of NWAU value and associated AN-ACC classification weightings reflects the true cost of allied health needs.[19]

Nevertheless, as we have submitted, IHACPA costing methodology remains profoundly limited by the fact that it only counts what allied health care is currently provided, and not what is actually needed by each individual resident. Accordingly, AHPA supports the development of a pilot study as recommended by our member Speech Pathology Australia.

Recommendation 4

In order to inform accurate pricing advice, IHACPA should recommend to the Commonwealth Government that a pilot study be funded to capture appropriate data examining the real cost of allied health care per AN-ACC class.

Recommendation 5

IHACPA should work with the Commonwealth Government to adjust the AN-ACC pricing framework to reflect the costs of providing allied health services based on individually assessed allied health needs.

If allied health funding is to be closely aligned to the provision of care that is needed, IHACPA advice to Government must address the current gaps in allied health costing and pricing discussed in this submission. This should include drawing Government attention to the true cost of providing needs-based allied health care to a reablement standard.

[19] See eg Professor Kathy Eagar and Dr Conrad Kobel, Australian Health Services Research Institute, 'Letter to Beth Midgley, Director Policy', Royal Commission into Aged Care Quality and Safety, October 2020, 2-3.